MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

• 1384 **CERTIFICATE OF DEATH**

Reg. Dist. No. 01358

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09x22 Hurlock
d. STREET ADDRESS: Not given
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: Last: Anderson
4. DATE OF DEATH: Month: 2 Day: 26 Year: 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Not given
9. AGE (In years last birthday): 61? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Cannery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Not given
14. MOTHER'S MAIDEN NAME: Not given
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records Address: Crownsville State Hospital Cambridge Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia

610 X

DUE TO (b) Prostatic Hypertrophy with urinary retention

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized and cerebral arteriosclerosis, Right hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/25, 1957, to 2/26, 1957, that I last saw the deceased alive on 2/25, 1957, and that death occurred at 10:00 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D. ADDRESS (Street, city or town, state): Crownsville, Md. DATE SIGNED: 2/26/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, MdD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/2/57
22c. NAME OF CEMETERY OR CREMATORY: Church Cemetery
22d. LOCATION (City, town, or county) (State): Pocomoke City, Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Stewart ADDRESS: Funeral Home, Salisbury, Md
24a. REC'D BY REGISTRAR DATE: MAR 5 1957
24b. REGISTRAR'S SIGNATURE: K. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1350

CERTIFICATE OF DEATH

01359

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wilson Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Elizabeth City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampton 83 x 3
d. STREET ADDRESS: 3911 Shell Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERNARD — Middle JAMES — Last APPERSON SR
4. DATE OF DEATH: Month FEBRUARY — Day 1 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 8, 1877
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Funniture
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Eli Arperson
14. MOTHER'S MAIDEN NAME: Mary K. Davenport
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 272 09 1889
17. INFORMANT: Mrs Robert E. Coleman-Daughter — Address: Wilson Rd. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of prostate c metastasis — INTERVAL BETWEEN ONSET AND DEATH: 7 yr.
177x
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
420 Arteriosclerotic CVD c angina
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1/ 1957 to 2/1/ 1957 that I last saw the deceased alive on 2/1/ 1957, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Shipley M.D.
ADDRESS (Street, city or town, state): 63 College Ave. Annapolis, Maryland
DATE SIGNED: February 2, 1957
PHYSICIAN'S NAME (Type): Frank Shipley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5-57
22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
22d. LOCATION (City, town, or county) (State): Hampton, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR: DATE FEB 5 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01360

Reg. Dist. No. 74

1385

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 40 y.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Boulevard Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Vincent Henry Bailey Middle Last
4. DATE OF DEATH: Month February Day 13th. Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/17/06
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Westinghouse Electronic Dept.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Bailey
14. MOTHER'S MAIDEN NAME: Josephine Skipper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-24-1273
17. INFORMANT: Mr. Thomas Bailey (brother) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Hypertension — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D.
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/14/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 16, 57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Rd. Anne Arundel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard Lindsay Allen
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: FEB 18 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dallas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1351 **CERTIFICATE OF DEATH** 01361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 183 Shipwright
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle S. Last Bean
4. DATE OF DEATH: Month Feb. Day 23 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-13-1879
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Building Homes
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Bean
14. MOTHER'S MAIDEN NAME: Elizabeth Stevens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret L. Bean Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2-4 hrs.
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/22, 1957, to 2/23, 1957, that I last saw the deceased alive on 2/23, 1957, and that death occurred at NOON M, from the causes and on the date stated above.

ACTUAL SIGNATURE John L. Hedeman M.D. ADDRESS (Street, city or town, state) 90 Cathedral St. DATE SIGNED 2/23/57

PHYSICIAN'S NAME (Type) JOHN HEDEMAN 90 CATHEDRAL St. ANNAPOLIS MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-26-1957
22c. NAME OF CEMETERY OR CREMATORY: St. ANNE'S CEMETERY
22d. LOCATION (City, town, or county) (State): ANNAPOLIS Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son ADDRESS: Annapolis Md
24a. RECD BY REGISTRAR DATE: FEB 25 1957
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01362

1386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A.County MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 551 Shipley Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. County

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.

d. STREET ADDRESS 551 Shipley Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Minnie Louise Middle Berry Last

4. DATE OF DEATH Month Feb. Day 23 Year 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Mar. 24, 1889

9. AGE (In years last birthday) 67 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Jamesville, N.C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John H. Bailey

14. MOTHER'S MAIDEN NAME Fannie Calloway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-16-7413 A

17. INFORMANT John H. Berry, Address 551 Shipley Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

260X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic cardio-vascular disease

DUE TO

(c) Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

420.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 10, 1943, to Feb. 23, 1957, that I last saw the deceased alive on Feb. 22, 1957, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE George A. Knipp M.D. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 2/25/57

PHYSICIAN'S NAME (Type) George A. Knipp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 2-27-57

22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge

22d. LOCATION (City, town, or county) (State) Howard County

23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave

24a. REC'D BY REGISTRAR DATE FEB 27 1957

24b. REGISTRAR'S SIGNATURE A. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1387 **CERTIFICATE OF DEATH** Reg. Dist. No. 01363

1. PLACE OF DEATH a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 9 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 3
d. STREET ADDRESS: 2462, Lakeview Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle Last BILLUPS
4. DATE OF DEATH: Month February Day 1 Year 1957
5. SEX: M
6. COLOR OR RACE: Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 12, 1900
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm hand
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Billups
14. MOTHER'S MAIDEN NAME: Mary (MN) Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Horace Billups Address: 2462 Lakeview Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS

420.1

DUE TO (b) HYPERTENSIVE ARTERIOSCLEROTIC

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) CARDIOVASCULAR DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-24, 1957, to 2-1, 1957, that I last saw the deceased alive on 2-1, 1957, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. ADDRESS (Street, city or town, state): CROWNSVILLE STATE HOSPITAL DATE SIGNED:

PHYSICIAN'S NAME (Type): L. BENEDICT M.D. CROWNSVILLE Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Feb. 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: Rise Valley
22d. LOCATION (City, town, or county) (State): Glouchester Co, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible]
24a. REC'D BY REGISTRAR DATE: FEB 5 1957
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01364

1352

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 113 Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 113 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle A Last BLAY
4. DATE OF DEATH: Month February Day 28 Year 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Sept 17, 1890
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Plumber
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.
11. BIRTHPLACE (State or foreign country): Lansing, Mich
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David A. Blay
14. MOTHER'S MAIDEN NAME: Lydia Vernetta
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr W.Garrett Larrimore- Daughter-Edgewater,Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease
420.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes
20c. TIME OF INJURY: Hour 6 a. m. Month, Day, Year 2-28-57 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from Natural cause ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Elmer G. Linhardt
DATE SIGNED: February 28, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 2,57
22c. NAME OF CEMETERY OR CREMATORY: St. Anne's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] Hopping Funeral Home
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE MAR 4 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Fuenche

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01365

1388

Reg. Dist. No. 22

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: Few seconds
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 175

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyatsville
d. STREET ADDRESS: 5103 52rd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Louis — Last: Bollinger

4. DATE OF DEATH: Month: February — Day: 24th. — Year: 19 57

5. SEX: M

6. COLOR OR RACE: W.

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12/1/13

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___ IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pittsburg, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William A Bollinger

14. MOTHER'S MAIDEN NAME: Sadie Tranc

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Automobile operator's license

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b) Comp. and comm. fratures of msndible and maxillar — "
DUE TO
(c) Comp and comm. fratures of ulnar and radius — "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Crushed chest. Multiple lacerations of face,

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Collided with an other automobile.

20c. TIME OF INJURY Hour: 12.10 a. m. P.M. Month, Day, Year: 2/24/57 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 175

20f. (City or town): Odenton (County): A.A. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2/24/57

EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/28/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 28 1957

24b. REGISTRAR'S SIGNATURE: Thelma Taylor

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01366

1389

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH

COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville (Rural) LENGTH OF STAY (in this place) 59 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodland & Pasadena Rds.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville,

STREET ADDRESS (If rural give location) Woodland & Pasadena Rds.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Bolm

4. DATE OF DEATH (Month) Feb. (Day) 10 (Year) 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 24, 1897

9. AGE last birthday: 59 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millworker

10b. KIND OF BUSINESS OR INDUSTRY: Wurzberger Co.

11. BIRTHPLACE (State or foreign country): Pasadena, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Bolm

14. MOTHER'S MAIDEN NAME: Eleanor Meyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 216-03-5605

17. INFORMANT & ADDRESS: Mrs Margeret Bolm, same as 2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1 IMMEDIATE CAUSE (A) Carcinoma of the Thoax & Lungs — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 1956

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Thoax

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19 56, to Feb 10 19 57, that I last saw the deceased alive on Feb 9 19 57, and that death occurred at 5 P.M. from the causes and on the date stated above.

SIGNATURE James S. Bellenyolo M.D. **ADDRESS** (Street, city, town, state) 108 Central Av Glen Burnie **DATE SIGNED** Feb 12/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Feb. 13, 57

NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

LOCATION (City, town, or county) (State): Glen Burnie, Md.

24. REC'D BY REGISTRAR DATE 2/14/57

REGISTRAR'S SIGNATURE Katherine M. Joyce

25. FUNERAL DIRECTOR'S SIGNATURE Hopkins & Kirkley ADDRESS Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01367

1390

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pine Wiff Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Edgewater
d. STREET ADDRESS: Pine Wiff Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle H Last BRASHEARS

4. DATE OF DEATH: Month FEBRUARY Day 15, Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 16, 1876
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Hirsch
14. MOTHER'S MAIDEN NAME: Babette Lehman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): nO
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-07-9351
17. INFORMANT: Mrs Bertha Schelley- Sister- Same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) gen. carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
171X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) carcinoma of cervix
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/20/57, 19____, to 2/15/57, 19____, that I last saw the deceased alive on 2/14/57, 19____, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE S. Borsuck M.D. — ADDRESS (Street, city or town, state): Amos Garrett Blvd Annapolis, Md — DATE SIGNED 2/16/57

PHYSICIAN'S NAME (Type): S. Borsuck MD — Amos Garrett Blvd. Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 18, 1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln,
22d. LOCATION (City, town, or county) (State): Prince George County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: HOPPING FUNERAL HOME ANNAPOLIS, MARYLAND
24a. REC'D BY REGISTRAR DATE FEB 1[illegible] 195[illegible]
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 [illegible] 11 2-25-57 et

1391

CERTIFICATE OF DEATH

01368

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Glen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Forest Glen
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LENA Middle BROOKS Last
4. DATE OF DEATH: Month 2/18/57 Day Year 19
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/18/60
9. AGE (In years last birthday): 96 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Gottleib Dais
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family - Same Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years
440.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9(28) DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of the left hip - January 10, 1955
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 10, 1957, to February 18, 1957, that I last saw the deceased alive on February 17, 1957, and that death occurred at 10:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): Mountain Road, Pasadena, Md. DATE SIGNED: Feb. 18, 1957

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 2/22/57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Homes - 130 E. Fort Ave. ADDRESS:
24a. REC'D BY REGISTRAR DATE: FEB 20 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dalbey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

CERTIFICATE OF DEATH

01369

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 4yrs.4mos.24days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
d. STREET ADDRESS 3425 Piedmont Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Edith Middle Last Brown
4. DATE OF DEATH Month 2 Day 23 Year 1957
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 12/31/96
9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY - - -
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Benjamin Green
14. MOTHER'S MAIDEN NAME Lucinda Green
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO Unk.
17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

442X

DUE TO (b) Cerebrovascular Accident - probably Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertensive Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/5, 19 57, to 2/23, 19 57, that I last saw the deceased alive on 2/20, 19 57, and that death occurred at 4:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/23/57

PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 28, 1957
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.
22d. LOCATION (City, town, or county) (State) Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Mrs Katie R. Williams ADDRESS 322 N. Schroeder St
24a. REC'D BY REGISTRAR DATE FEB 28 1957
24b. REGISTRAR'S SIGNATURE L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filmed 2-26-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 01370

Item 9 Filmed 2-26-57 et

1353

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE: Maryland b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 402 Chester Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence Middle: Last: Brown
4. DATE OF DEATH: Month: 2 Day: 3 Year: 1957
5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-13-1894
9. AGE (In years if not birthday): 62 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lothian, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Johnson
14. MOTHER'S MAIDEN NAME: Delia Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Ethelda Johnson Address: 402 Chester Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Annapolis (County) A. A. (State) Md.

21. I certify that I attended the deceased from 1-21-57, 19____, to 2-3-57, 19____, that I last saw the deceased alive on 2-2-57, 19____, and that death occurred at 12 m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: K. T. Ally M.D. ADDRESS (Street, city or town, state): 62 Cathedral St. DATE SIGNED: 2-4-57

PHYSICIAN'S NAME (Type): K. T. Ally Annapolis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-7-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: 2/10/57
24b. REGISTRAR'S SIGNATURE: R. Wm. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01371

1393

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 2 Feb 57
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
d. STREET ADDRESS: 162 D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: RODRICK — Middle: I — Last: BROWN
4. DATE OF DEATH: Month: February — Day: 7 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 May 1942
9. AGE (In years last birthday): 14 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Woodrow Wilson Brown
14. MOTHER'S MAIDEN NAME: Barbara Edith Pope
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Chronic glomerulonephritis with uremia

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Feb, 1957, to 7 Feb, 1957, that I last saw the deceased alive on 7 Feb, 1957, and that death occurred at 0630 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Said H. Tarabishy M.D. — ADDRESS (Street, city or town, state): USAH, FGGM, Md. — DATE SIGNED: 7 Feb 57

PHYSICIAN'S NAME (Type): SAID H. TARABISHY, Major, MC, USAH, Fort George G. Meade, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 1957
22c. NAME OF CEMETERY OR CREMATORY: Carson Valley
22d. LOCATION (City, town, or county) (State): Duncansville Pa.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ridgley Selby, Laurel, Md
24a. REC'D BY REGISTRAR DATE: 7 Feb 57
24b. REGISTRAR'S SIGNATURE: W. L. SAYLOR, 1ST LT, MSC.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01372

1394

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn

LENGTH OF STAY (in this place) 23 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS Telegraph Road

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn

STREET ADDRESS (If rural give location) Telegraph Road

3. NAME OF DECEASED (Type or Print) (First) Roy (Middle) Richard (Last) Burns

4. DATE OF DEATH (Month) 2 (Day) 16 (Year) 1957

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 27, 1889

9. AGE last birthday: 68 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mar. (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Elite Laundry

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan T. Burns

14. MOTHER'S MAIDEN NAME: Annie L. Sherriff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 215-03-5074

17. INFORMANT & ADDRESS: Mrs. Roberta Burns Same Addr.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 Mos

DUE TO (B) Hypertensive Cardio Vascular Disease

DUE TO (C)

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1953, to Feb., 1957, that I last saw the deceased alive on Feb. 8, 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE Charles R McDonald M.D. — ADDRESS (Street, city, town, state) Glen Burnie Md — DATE SIGNED 2-16-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Feb. 19, 1957 — NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. — LOCATION (City, town, or county) (State): Baltimore, Md.

24. REC'D BY REGISTRAR DATE FEB 19 1957 — REGISTRAR'S SIGNATURE Clara Hadley

25. FUNERAL DIRECTOR'S SIGNATURE T V Singleton — ADDRESS Glen Burnie, Md.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01373

1354

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Naval Hos.ital,Annapolis,Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Maryland
d. STREET ADDRESS: 74 South Gate Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert — Middle: Edward — Last: CARONNA
4. DATE OF DEATH: Month: February — Day: 14 — Year: 1957
5. SEX: M
6. COLOR OR RACE: CAU.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/19/11
9. AGE (In years last birthday): 45 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USN Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Musician
11. BIRTHPLACE (State or foreign country): N .Y.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Lewis Caronna
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1928 -1955
16. SOCIAL SECURITY NO.: 213-36-4355
17. INFORMANT: USNH Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic Thrombocytopenic Purpura — INTERVAL BETWEEN ONSET AND DEATH: 22 days

296X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-23, 1957, to 2-14-, 1957, that I last saw the deceased alive on 2-14-57, 1957, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Vincent P. Butler, Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): V.P. BUTLER JR — LT MC U.S. Navy — 2/15/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-18-57
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR: DATE FEB 19 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1355 **CERTIFICATE OF DEATH**

01374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Skidmore, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: Maryland b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 152 Annapolis
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest Middle: Edward Last: Carr
4. DATE OF DEATH: Month: 2 Day: 2 Year: 1957
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4-23-1918
9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Experimental
11. BIRTHPLACE (State or foreign country): Skidmore, Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: William T. Carr
14. MOTHER'S MAIDEN NAME: Ella Cromwell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ella Carr Address: Rt 2 B/416 Annap. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary. Insufficiency — 17 yr.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/2, 1957, to 2/2, 1957, that I last saw the deceased alive on 1/2, 1957 and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Johnson M.D. ADDRESS (Street, city or town, state): 37 Cathedral Street Annapolis DATE SIGNED: 2/2/57
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5-57
22c. NAME OF CEMETERY OR CREMATORY: Broadneck
22d. LOCATION (City, town, or county) (State): Skidmore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Delbert Reese, II ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 4 1957
24b. REGISTRAR'S SIGNATURE: Jm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1356

CERTIFICATE OF DEATH

Reg. Dist. No. 21 01375

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva X
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HARRISON Middle [illegible] Last CARR

4. DATE OF DEATH: Month FEBRUARY Day 7 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 18, 1869
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Baltimore Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Amos C. Carr
14. MOTHER'S MAIDEN NAME: Mary Lancaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Benjamin Carr- Daughter- same as # 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b) Arteriosclerotic Cardiovascular Disease — Unknown
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 February 1957 to 7 February 1957, that I last saw the deceased alive on 7 February 1957, and that death occurred at 2:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D. ADDRESS (Street, city or town, state): 41 Southgate Ave Annapolis DATE SIGNED: 2/8/57

PHYSICIAN'S NAME (Type): Edward S. Beck Southgate Ave., Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-9-1957
22c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial
22d. LOCATION (City, town, or county) (State): Millersville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping Funeral Home Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 11 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1395 **CERTIFICATE OF DEATH** 01376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Annapolis
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EARL Middle: JAMES Last: CASSADY
4. DATE OF DEATH: Month 2 Day 21 Year 19 57
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/19/1883
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard U.S.N.E.t.S.
10b. KIND OF BUSINESS OR INDUSTRY: Guard (Ret.)
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unk.
14. MOTHER'S MAIDEN NAME: Unk.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. 1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary E. Cassady #2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple cerebrovascular accidents — 24 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/20, 19 57, to 2/27, 19 57, that I last saw the deceased alive on 2/20, 19 57, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE John L. Hedeman M.D. ADDRESS (Street, city or town, state) 90 Cathedral St DATE SIGNED 2/23/57

PHYSICIAN'S NAME (Type) JOHN HEDEMAN 90 CATHEDRAL ST. ANNAPOLIS MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/25/57
22c. NAME OF CEMETERY OR CREMATORY: Annapolis Nat'l.
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor and Sons ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 25 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1357

CERTIFICATE OF DEATH

01377

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Skidmore
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF [redacted] (Type or print): First Gregory Middle Last Chambers

4. DATE OF DEATH: Month Feb. Day 8 Year 1957

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 10 1957
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months Days 29
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Houston Chambers
14. MOTHER'S MAIDEN NAME: Earline Henson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Earline Henson Skidmore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 053.4
DUE TO (b):
DUE TO (c): Septicemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Febr. 7, 1957, to Febr. 8, 1957, that I last saw the deceased alive on Febr. 8, 1957, and that death occurred at 1:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Norton M.D. ADDRESS (Street, city or town, state): 95 Cathedral St. DATE SIGNED: 2/9/57
PHYSICIAN'S NAME (Type): CLAYTON NORTON Annapolis, Md.

22a. BURIAL, CREMATION, ~~REMOVAL~~ (Specify): Burial
22b. DATE THEREOF: Feb 10 1957
22c. NAME OF CEMETERY OR CREMATORY: Broadneck
22d. LOCATION (City, town, or county) (State): St. Margrette Md

23. FUNERAL DIRECTOR'S SIGNATURE: Anne A. Johnson ADDRESS: Annapolis
24a. REC'D BY REGISTRAR DATE 2/14/57
24b. REGISTRAR'S SIGNATURE: Wm J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2 191XY5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1396 **CERTIFICATE OF DEATH** 01378 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 14yrs.8mos.23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3V. 4
d. STREET ADDRESS: 933 Pennsylvania Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary Middle E. Last Clements
4. DATE OF DEATH: Month 2 Day 10 Year 1957
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ Unknown NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1887?
9. AGE (In years last birthday): 69? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Not given
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Not given
14. MOTHER'S MAIDEN NAME: Not given
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records Address: Crownsville State Hosp. Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular renal disease

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/28, 1957 to 2/10, 1957, that I last saw the deceased alive on 2/8, 1957, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state): Crownsville, Md. DATE SIGNED: 2/11/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 14 Feb. 56
22c. NAME OF CEMETERY OR CREMATORY: Univ. of Md. Med. School
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE 2-18-57
24b. REGISTRAR'S SIGNATURE: H. M. Jordan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01379

1397

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 4yr.8mos.17days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS Jersey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

10

3. NAME OF DECEASED (Type or print) First Catherine Middle Last Collins

4. DATE OF DEATH Month 2 Day 6 Year 19 57

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH 7/10/05

9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Housework

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Fletcher Collins

14. MOTHER'S MAIDEN NAME Mancy Mae West

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac arrest
DUE TO (b) Epileptiform convulsion
DUE TO (c)

434.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Convulsive disorder of unknown etiology

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/3, 19 57 to 2/6, 19 57 that I last saw the deceased alive on 2/6, 19 57, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Lionel McHenry Magee M.D.
ADDRESS (Street, city or town, state) Crownsville, Md.
DATE SIGNED 2/6/57
PHYSICIAN'S NAME (Type) Lionel McHenry Magee, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/10/57
22c. NAME OF CEMETERY OR CREMATORY Glass Hill
22d. LOCATION (City, town, or county) (State) Parsonburg Md

23. FUNERAL DIRECTOR'S SIGNATURE D. F. Stewart
ADDRESS Funeral Home Salisbury Md
24a. REC'D BY REGISTRAR DATE FEB 13 1957
24b. REGISTRAR'S SIGNATURE H. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1358 **CERTIFICATE OF DEATH** Reg. Dist. No. 01380

1 PLACE OF DEATH a. COUNTY: A A — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A A

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. STREET ADDRESS: 1217 McKinley St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle CRANDALL Last

4. DATE OF DEATH: Month 2 Day 28 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 20-1881

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Est (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): A A Co Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Crandall

14. MOTHER'S MAIDEN NAME: Mary Wason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Anna Dawson Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Cerebral Vascular, Rupt

DUE TO (b) Disease i decompensation

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 14, 1956 to 2/28, 1956 that I last saw the deceased alive on 2/27/57, 19____, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Klawans M.D. ADDRESS (Street, city or town, state): Annapolis, Md DATE SIGNED: 2/28/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-2-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemt

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 3/1/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01381

1398 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: a a — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: A A

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Halesville

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Fidlesville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLOTTE — Middle: — Last: CROWNER

4. DATE OF DEATH: Month: February — Day: 28 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 4 1890

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberstone Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thos. Crowner

14. MOTHER'S MAIDEN NAME: Alice Crowner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 212-18-5645

17. INFORMANT: Wm Crowner — Address: Fidlesville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Failure
4 4.
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-12-56, 19__, to 2-28-57, 19__, that I last saw the deceased alive on 2-21-57, 19__, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A T Alley — M.D. — ADDRESS (Street, city or town, state): 6 L Cumberland St — DATE SIGNED: 3-1-57

PHYSICIAN'S NAME (Type): A T ALLEY — Cumberland Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 3/57

22c. NAME OF CEMETERY OR CREMATORY: Crowners

22d. LOCATION (City, town, or county) (State): Fidlesville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Burnard Hardesty — ADDRESS: Halesville Md

24a. REC'D BY REGISTRAR — DATE:

24b. REGISTRAR'S SIGNATURE: [illegible]

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. [redacted] 1 and 2 should be filed with [redacted]strar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1399

CERTIFICATE OF DEATH

01382 A

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1yr.2mos.17days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 V 1 4
d. STREET ADDRESS: 402 Myrtle Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Winters; Middle; Last Dailey
4. DATE OF DEATH: Month 2; Day 27; Year 19 57
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/4/89
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records; Address: Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
4 D.
DUE TO (b) Senility and generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Thrombosis and Aneurism of Aorta
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/26, 1957, to 2/27, 1957, that I last saw the deceased alive on 2/27, 1957, and that death occurred at 5:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 2/28/57
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/3/57
22c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEM.
22d. LOCATION (City, town, or county) (State): BROOKLYN, A.A. Co. MD
23. FUNERAL DIRECTOR'S SIGNATURE: Jas. E. O. Wilson
ADDRESS: 1000 BRANTLEY AVE.
24a. REC'D BY REGISTRAR DATE: 3/1/57
24b. REGISTRAR'S SIGNATURE: L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pa[illegible] and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01383

1359

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hosptial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Annapolis
d. STREET ADDRESS: Weems Creek
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Regina — Middle: Ellen — Last: DAWSON

4. DATE OF DEATH: Month: February — Day: 23 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 8, 1957

9. AGE (In years last birthday): — yrs. — IF UNDER 1 YEAR: Months —, Days 15 — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas N. Dawson

14. MOTHER'S MAIDEN NAME: Florence R. Garner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — — — (If yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO.: — — —

17. INFORMANT: Address: Thomas N. Dawson- Father- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 7/lb x
DUE TO
(b):
DUE TO
(c): Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 8, 1957, to Feb. 23, 1957, that I last saw the deceased alive on Feb. 22, 1957, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Norton M.D. — ADDRESS (Street, city or town, state): 95 Cathedral St. — DATE SIGNED

PHYSICIAN'S NAME (Type): Clayton Norton — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 25, 57

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: ANNAPOLIS, MD.

24a. REC'D BY REGISTRAR — DATE 2/26/57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01384

1360 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Homewood Convl. Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

STREET ADDRESS (If rural give location): 6 Dogwood Rd.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) Amy (Last) DEARTH

4. DATE OF DEATH (Month) FEB (Day) 25 (Year) 1957

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 26, 1882

9. AGE last birthday: 74 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Melford Jordan

14. MOTHER'S MAIDEN NAME: Mary Cummings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): — — —

(If Yes, give war or dates of service): — — — —

16. SOCIAL SECURITY NO.: — — — —

17. INFORMANT & ADDRESS: George C. Dearth- Son - same as # 2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 6 HRS

DUE TO

ANTECEDENT CAUSE(S) (B) CORONARY ARTERY SCLEROSIS — 3 YRS

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: METASTATIC CARCINOMA OF CERVIX — 2 YRS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/18, 1957, to 2/25, 1957, that I last saw the deceased alive on 2/25, 1957, and that death occurred at 10:45 P.M., from the causes and on the date stated above. 2/25/57

SIGNATURE: John E. Hedimon M.D.

ADDRESS (Street, city, town, state): 90 Cathedral St. Annapolis, Md.

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: March 1, 57

NAME OF CEMETERY OR CREMATORY: Lafayette Memorial Park

LOCATION (City, town, or county) (State): Chestnut Ridge, Pa

24. REC'D BY REGISTRAR — DATE

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME

ADDRESS: Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1361

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 01385

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hosptial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LULA — Middle LEE — Last DOLAN

4. DATE OF DEATH: Month February — Day 20 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 31, 1894
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Ky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ben Gregory
14. MOTHER'S MAIDEN NAME: Dora Spradlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - - - (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT — Address: Mr. Jack Dolan- Husband- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS
DUE TO
(b) Arteriosclerosis — unknown
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 MARCH, 1956, to 20 FEB, 1957, that I last saw the deceased alive on 20 FEB, 1957, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave Annapolis — DATE SIGNED: 2/20/57

PHYSICIAN'S NAME (Type): Edward S. Beck MD 41 Southgate Ave. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-23-57
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR, DATE: FEB 20 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1420 **CERTIFICATE OF DEATH**

01386

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Laurel Acres, Pasadena Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: Laurel Acres, Pasadena Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Shepherd; Middle: ; Last: Drain Jr.

4. DATE OF DEATH: Month: Feb.; Day: 7; Year: 1957

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 31, 1906

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dr. Shepherd Drain

14. MOTHER'S MAIDEN NAME: Maud

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Dorothy Drain, Laurel Acres, Pasadena

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Kidney — INTERVAL BETWEEN ONSET AND DEATH: 18 mnth
161X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 6, 1957, to Feb. 7, 1957, that I last saw the deceased alive on Feb. 6, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. ADDRESS (Street, city or town, state): RIVIERA BEACH, MD DATE SIGNED: 2/8/57

PHYSICIAN'S NAME (Type): J. BRADY SMITH PASADENA, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 9/57

22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge

22d. LOCATION (City, town, or county) (State): Pikesville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry H. Witzke, 4101 Edmondson Ave.

24a. REC'D BY REGISTRAR: DATE FEB 11 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dealba

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01387

CERTIFICATE OF DEATH

1491

Reg. Dist. No. 54

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Margate, Glen Burnie
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Leymar Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X. Margate , Glen Burnie
d. STREET ADDRESS: Leymar Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Max — Middle: Richard — Last: Eschenbach

4. DATE OF DEATH: Month: Feb. — Day: 18 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 24, 1889

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): StoreKeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Store

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oscar Albert Eschenbach

14. MOTHER'S MAIDEN NAME: Lena Ludwig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO: 218-32-3923

17. INFORMANT: William Eschenbach, Address: 516 First Ave SW, Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio hypertensive vascular diseases — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(b) Blind
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 55, to Feb. 18, 19 57, that I last saw the deceased alive on 2/18/57, 19, and that death occurred at 1 0 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 21 1957

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Baltimore 25, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James D. Kirkley — ADDRESS: Hopping and Kirkley, Glen Burnie, Md

24a. REC'D BY REGISTRAR — DATE: FEB 21 1957

24b. REGISTRAR'S SIGNATURE: L. J. Dellinger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File ... et

1362

01388

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
d. STREET ADDRESS: 22 Munroe Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: Emmanuel

4. DATE OF DEATH: Month: Feb. Day: 4 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10b. KIND OF BUSINESS OR INDUSTRY: Tavern
11. BIRTHPLACE (State or foreign country): Turkey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Malama Emanuel — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma c̄ cerebral metastasis — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.
162 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to Feb. 4, 1957, that I last saw the deceased alive on Feb 4, 1957, and that death occurred at 2 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedeman M.D. — ADDRESS (Street, city or town, state): 90 Cathedral St., Annapolis, Md. — DATE SIGNED: 2/4/57

PHYSICIAN'S NAME (Type): Dr. John L. Hedeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-6-1957
22c. NAME OF CEMETERY OR CREMATORY: St. Margaret's
22d. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR: DATE 2/5/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Jas. Emanuel

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1402

CERTIFICATE OF DEATH

Reg. Dist. No. 01388

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 20yrs.11mos.6days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 484 Prestman St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: — Last: Giles
4. DATE OF DEATH: Month: 2 — Day: 10 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1895?
9. AGE (In years last birthday): 62? yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Launderer
10b. KIND OF BUSINESS OR INDUSTRY: Laundry
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Thomas Giles
14. MOTHER'S MAIDEN NAME: Sallie Giles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: - -
17. INFORMANT: Hospital Records — Address: State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis

443X

DUE TO (b) Hypertensive cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Tabo-paresis with Charcot's joint

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/8, 19 57, to 2/10, 19 57, that I last saw the deceased alive on 2/8, 19 57, and that death accurred at 11:15 p. m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp. M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 2/11/57
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-18-57
22c. NAME OF CEMETERY OR CREMATORY: Md. Hosp.
22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR: DATE FEB 19 1957
24b. REGISTRAR'S SIGNATURE: D. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01390

1403

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 1625 Madison Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Hampton — Last: Goldman

4. DATE OF DEATH: Month: 2 — Day: 10 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Not given

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: William Henry

14. MOTHER'S MAIDEN NAME: Not given

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: State Hospital, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Senility — INTERVAL BETWEEN ONSET AND DEATH

442X

DUE TO (b) Cardiovascular-renal Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2608

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus, mild and malnutrition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/22, 19 57 to 2/10, 1957, that I last saw the deceased alive on 2/8, 1957, and that death occurred at 8:38 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 2/11/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/15/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arlington S. Blake
ADDRESS: 1808 Mt. Royal Ave

24a. REC'D BY REGISTRAR DATE 2-13-57

24b. REGISTRAR'S SIGNATURE: K. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1363

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 01391

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: Maryland b. COUNTY: A.A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1904 Drew St. - Annapolis, Md.

d. STREET ADDRESS: 1904 Drew St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charlie Middle: Lost: Brandison Jr.

4. DATE OF DEATH: Month: 2 Day: 28 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-28-1900

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Naval Acad.

11. BIRTHPLACE (State or foreign country): Waterproof La.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charlie Brandison Sr.

14. MOTHER'S MAIDEN NAME: Millie Brandison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 219-16-0773

17. INFORMANT: Annie E. Brandison Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-24-44, 19____ to 2-28-57, 19____, that I last saw the deceased alive on 2-22-57, 19____, and that death occurred at 12:32 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A T Allen M.D. ADDRESS (Street, city or town, state): 62 Cathedral St. DATE SIGNED: 3-2-57

PHYSICIAN'S NAME (Type): A T Allen Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-4-57

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Leise ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 1957

24b. REGISTRAR'S SIGNATURE: M E Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1364 **CERTIFICATE OF DEATH** Reg. Dist. 21 01392

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 College Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 18 College Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Harriet Middle Lost Gross
4. DATE OF DEATH Month 2 Day 16 Year 1957
5. SEX Female 6. COLOR OR RACE Col. 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-5-1877
9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Prettyriver, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Gross
14. MOTHER'S MAIDEN NAME Louise Gross
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Helen Rawlings Address Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of the Liver
443X
DUE TO
(b) Cardiovascular disease - Grade 6 months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 22, 1956, to Feb 16, 1957, that I last saw the deceased alive on Feb 16, 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE R. L. Richardson M.D. ADDRESS (Street, city or town, state) 118 - Clay St. Ann Apolis, Md. DATE SIGNED 2/18/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-20-57
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill
22d. LOCATION (City, town, or county) (State) Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese II ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE MAR 4 1957
24b. REGISTRAR'S SIGNATURE Wm. J. Brady

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Po[illegible] and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,13,14 Tel. call 2-25-57 et

1904

CERTIFICATE OF DEATH

01393

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 1yr.5mos.20days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
d. STREET ADDRESS 1340 Stockton St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Veretta Middle Last Harvey
4. DATE OF DEATH Month 2 Day 13 Year 19 57
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ Unk. NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 66? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Alex Pratt
14. MOTHER'S MAIDEN NAME Betsy Pratt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

422.2

DUE TO (b) Senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dehydration, Malnutrition, Decubitus Ulcers

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/25, 1956, to 2/13, 1957, that I last saw the deceased alive on 2/13, 1957, and that death occurred at 4:40 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/14/57

PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-20-57
22c. NAME OF CEMETERY OR CREMATORY Mt Zion
22d. LOCATION (City, town, or county) (State) AA County

23. FUNERAL DIRECTOR'S SIGNATURE Charles Alexander ADDRESS 2700 Edmondson
24a. REC'D BY REGISTRAR DATE 2-18-57
24b. REGISTRAR'S SIGNATURE L. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01394

1406 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE,

LENGTH OF STAY (in this place) 13 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD. COUNTY A.A.

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. LINTHICUM

STREET ADDRESS (If rural give location) 307 REGENCY CIRCLE

3. NAME OF DECEASED (Type or Print) (First) BLANCA (Middle) IRIS (Last) Hernandez

4. DATE OF DEATH (Month) FEB (Day) 19 (Year) 1957

5. SEX FEMALE

6. COLOR OR RACE CAUCASIAN

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —

8. DATE OF BIRTH FEB 6, 1957

9. AGE last birthday — yrs.

IF UNDER 1 YEAR: Months — Days 13

IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ENRIQUE HERNANDEZ

14. MOTHER'S MAIDEN NAME MARIA MILAGROS BREBAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS 307 REGENCY CIRCLE, N. LINTHICUM FATHER, ENRIQUE HERNANDEZ,

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 13 DAYS

ANTECEDENT CAUSE(S) DUE TO (B) Possible cerebral respir. immaturity — " "

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 FEB, 19 57, to 19 FEB 13, 19 57, that I last saw the deceased alive on 19 FEB 13, 19 57, and that death occurred at 2:05 P.M., from the causes and on the date stated above.

SIGNATURE James A. White, Capt MC. M.D. **ADDRESS** (Street, city, town, state) **DATE SIGNED**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — DATE THEREOF 2-21-57 — NAME OF CEMETERY OR CREMATORY BALTO NATIONAL — LOCATION (City, town, or county) BALTO (State) Md

24. REC'D BY REGISTRAR DATE FEB 19, 57 — REGISTRAR'S SIGNATURE W.L. Saylor, MSC LT. LT.

25. FUNERAL DIRECTOR'S SIGNATURE WILLIAM COCKEY — ADDRESS BALTIMORE 1217 St. Paul St.

Item 1 Film 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01395

1407 Item 2, Film G210, 2/8/57 bh

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hanover Nursery Roads

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Million — Middle: Evelyn — Last: Hinkle
4. DATE OF DEATH: Month: February — Day: 1St. — Year: 19 57

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/14/26
9. AGE (In years last birthday): 7930 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Million Osborn Woodston
14. MOTHER'S MAIDEN NAME: Evelynn Dora Philipps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Charles Hinkle, same as 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration of vomitus due to acute alcoholism
322.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Russell S. Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher
DATE SIGNED: 2-2-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/4/57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James E. Kirkley
ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR: DATE FEB 5 1957
24b. REGISTRAR'S SIGNATURE: A. H. Kedrick

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01396

Name: G211 2 20 ... Items 20&21 Film G211 5-1-57 ams

1405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Curtis Creek

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Md. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Balto.

d. STREET ADDRESS: 625 Grantley

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): Also known as ALFRED GOTTHARD HORNEY — First: Alfred Albert; Middle: E.; Last: Hornig

4. DATE OF DEATH: Month: Feb. Day: 8, Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN 24 1903

9. AGE (in years last birthday): 54

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: KRANZ-WILLS MUSIC CO

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: FREDERICK A. HORNIG

14. MOTHER'S MAIDEN NAME: SELMA HEYER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-16-3415

17. INFORMANT: MRS E HORNIG — Address: 625 GRANTLEY ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH:

975X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowned self

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Creek

20f. (City or town) (County) (State): Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William V. Lovitt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

DATE SIGNED: 2/11/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/13/57

22c. NAME OF CEMETERY OR CREMATORY: LORRAINE PARK

22d. LOCATION (City, town, or county) (State): WOODLAWN MD

23. FUNERAL DIRECTOR'S SIGNATURE: GEO H. LEIMBACH — ADDRESS: 52 S N LYNDHURST ST

24a. REC'D BY REGISTRAR: DATE 2-13-57

24b. REGISTRAR'S SIGNATURE: L. J. Dellhop

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1365

01397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 20 South Cherry Grove Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 20 S. Cherry Grove Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: W. Last: Hurlock
4. DATE OF DEATH: Month: 2 Day: 9 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-6-1872
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Calvert Co Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James H Jones
14. MOTHER'S MAIDEN NAME: Mary E. Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Leo D. Miller Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Azotemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) Arteriosclerosis generalized — 5 yr.
DUE TO (c) Arthritis Rheumatoid — 10 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 10, 1948 to Feb. 9, 1957 that I last saw the deceased alive on Feb. 9, 1957, and that death occurred at 1:05 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.
ADDRESS (Street, city or town, state): 6 Shaw St. Annapolis, Md.
DATE SIGNED: 2/11/57
PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-12-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layton Sons
ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 [illegible] 1-20-57 et

1408

CERTIFICATE OF DEATH

01398

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 1 mon 25 d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewater
d. STREET ADDRESS: 1 Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle WESLEY Last ISAACS
4. DATE OF DEATH: Month FEB Day 3 Year 1957
5. SEX: M
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-6-[illegible] 4/14/181[illegible]
9. AGE (In years lost birthday): 88[illegible] yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM LABOUR
10b. KIND OF BUSINESS OR INDUSTRY: FARMER
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Dorothy Isaacs — Address: Edgewater Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO
(b) Arteriosclerosis — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None.
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/18, 1956, to 2/3, 1957, that I last saw the deceased alive on 2/3, 1957, and that death occurred at 5:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 8913 GEORGIA AVE DATE SIGNED
PHYSICIAN'S NAME (Type): CYRIL G. HARDY SILVER SPRING Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-6-57
22c. NAME OF CEMETERY OR CREMATORY: Chews Chapel
22d. LOCATION (City, town, or county) (State): Owensville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mr. Bill Reese — ADDRESS: Wm. Reese II
24a. REC'D BY REGISTRAR DATE FEB 4 1957
24b. REGISTRAR'S SIGNATURE: A. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pa[illegible] and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01399

1366

Iss. 9 Rec'd 9211 2/57 bh

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hi-Larkins

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS Hi-Larkins
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle Last Johnson
4. DATE OF DEATH Month 2 Day 18 Year 1957
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister
10b. KIND OF BUSINESS OR INDUSTRY Church Minister
11. BIRTHPLACE (State or foreign country) David Sonyill Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Johnson
14. MOTHER'S MAIDEN NAME Matilda Spriggs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Maggie Johnson Address Hi-Larkins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction
443X
DUE TO (b) Cardiovascular disease Grade III
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 25, 1957 to Feb 18, 1957, that I last saw the deceased alive on Feb 18, 1957, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) 110 - Clay St Annapolis, Md. DATE SIGNED 2/20/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/21/57
22c. NAME OF CEMETERY OR CREMATORY Brewhill
22d. LOCATION (City, town, or county) Annapolis (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Ethel L. Hicks ADDRESS 43 Northwest Annapolis Md.
24a. REC'D BY REGISTRAR DATE 2/20/57
24b. REGISTRAR'S SIGNATURE Wm. J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1367 **CERTIFICATE OF DEATH** 01400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wardour
d. STREET ADDRESS: 113 Wardour Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Raymond Middle Henry Last Lacey
4. DATE OF DEATH: Month February Day 8 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 27, 1876
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Professor
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry W. Lacey
14. MOTHER'S MAIDEN NAME: Olive Durand
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Douglas Lacey Address: # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar pneumonia — 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Vascular accident — 3 day
DUE TO
(c) Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1955 to 2/8, 1957, that I last saw the deceased alive on 2/8, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. ADDRESS (Street, city or town, state): 63 College Ave DATE SIGNED: 2/10/57
PHYSICIAN'S NAME (Type): Frank M Shipley Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-11-57
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Laceyville Pa

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE:
24b. REGISTRAR'S SIGNATURE: U. Orrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M

1 Item 18 Film 212 01401

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1368 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pines on the Severn
d. STREET ADDRESS: x
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Scott Middle W. Last Lafferty
4. DATE OF DEATH: Month 2 Day 23 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 25th 1957
9. AGE (In years last birthday): 4 weeks
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Frank H. Lafferty
14. MOTHER'S MAIDEN NAME: Jean Whittock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Same as 13 — 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): [illegible]
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): F. FINHARDT.
DATE SIGNED: 2/13/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-25-57
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE FEB 25 1957
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01402

1409

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN 1b: Few seconds
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 170

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Meade
d. STREET ADDRESS: Home address: 424 Swale Ave. Baltimore, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Linwood — Last: Lewis

4. DATE OF DEATH: Month: February — Day: 16th. — Year: 1957

5. SEX: M.

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/4/27

9. AGE (In years last birthday): 29 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier in the U.S. Army

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Nattaway Co, VA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John B. Lewis

14. MOTHER'S MAIDEN NAME: Gladys May

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): In the army at present.

16. SOCIAL SECURITY NO.: 228-28-5527

17. INFORMANT — Address: Fort Meade Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden

S23X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile skidded on route 170

20c. TIME OF INJURY Hour: 6.15 a. m. / p. m. — Month, Day, Year: 2/16/57 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 170

20f. (City or town) (County) (State): Linthicum Heights, A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2/16/57

NAME (Type): Gustave H. Faubert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 20 Feb 57

22c. NAME OF CEMETERY OR CREMATORY: LEWIS (FAMILY) CEMETARY

22d. LOCATION (City, town, or county) (State): CROME, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Lar — ADDRESS: 802 Madison Ave, Balti 1, Md

24a. REC'D BY REGISTRAR — DATE: 19 Feb 57

24b. REGISTRAR'S SIGNATURE: L.L.SALLOR, 1/Lt. SC

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1410

CERTIFICATE OF DEATH

01403

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 118 Wilson Blv. S.W.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto city
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1432 Carroll St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MICHAEL Middle Last LITZ
4. DATE OF DEATH: Month FEB. Day 12th Year 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1[illegible]
9. AGE (In years last birthday): [illegible] yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furniture Finisher
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? yes USA
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: [illegible]
17. INFORMANT: Mrs Marg. Riley (daughter) Address: 118 Wilson Blv SW Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Arteriosclerotic Heart disease — 4 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4000

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous myocardial attack 6-mo ago.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): no
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): no injury.
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to 12 Feb, 1957, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H.F. Manuzak M.D. ADDRESS (Street, city or town, state): 901 Edgerly Rd, Glen Burnie DATE SIGNED: 12 Feb 57

PHYSICIAN'S NAME (Type): H.F. MANUZAK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 15, 1957
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. Singleton ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: Feb 14, 1957
24b. REGISTRAR'S SIGNATURE: L J D'Alba

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

Note: Patient of Dr. Chas. Mae DeFeo. Glen Burnie. I was under the constant care for some time. I was called when Dr Moe was not available.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01404

1411

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH a. COUNTY: Anne Arundel Co. MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn

c. LENGTH OF STAY IN 1b: Yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 713 Church Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: A.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 Brooklyn

d. STREET ADDRESS: 1529 Elmtree St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MRS Middle Antonia Last LUBAK

4. DATE OF DEATH: Month Feb Day 24 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April, 1887

9. AGE (In years lost birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Kosnik

14. MOTHER'S MAIDEN NAME: Eva Pryztulska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma of Colon with metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 9th, 1955, to Feb 24, 1957, that I last saw the deceased alive on Feb 24th, 1957, and that death occurred at 12:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W M Conway M.D. ADDRESS (Street, city or town, state): 5301 Har DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/27/57

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross

22d. LOCATION (City, town, or county) (State): Brooklyn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Homes ADDRESS: 130 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: FEB 26 1957

24b. REGISTRAR'S SIGNATURE: Ida Hutson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1412

CERTIFICATE OF DEATH

01405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Winfield Middle: Scott Last: Lyons Sr.
4. DATE OF DEATH: Month: 2 Day: 16 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28-1880
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farmer Tobacco
11. BIRTHPLACE (State or foreign country): West River Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William F. Lyons
14. MOTHER'S MAIDEN NAME: Elizabeth Peake
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Winfield S. Lyons Jr. Address: Edgewater Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(b): Arteriosclerosis Generalized — 2 yrs.
DUE TO
(c): Pulmonary Emphysema — 2 yrs.

330A

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1, 1952, to Feb. 16, 1957 that I last saw the deceased alive on 2-16-, 1957, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. ADDRESS (Street, city or town, state): 6 Shaw St. DATE SIGNED: 2/17/57
PHYSICIAN'S NAME (Type): JAMES R. MARTIN — ANNAPOLIS, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-19-57
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE:
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. [illegible] 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1369

01406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 116 Charles St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosaria Middle: Last: Maggio
4. DATE OF DEATH: Month: February Day: 25 Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7th 1872
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Antonio Citrano
14. MOTHER'S MAIDEN NAME: Agnese Miceli
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anthony J. Maggio Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Kidney — INTERVAL BETWEEN ONSET AND DEATH: 3 yr.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1, 1952 to Feb. 25, 1952, that I last saw the deceased alive on Feb. 24, 1957, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. Martin M.D. ADDRESS (Street, city or town, state): 6 Shaw St. Annapolis Md. DATE SIGNED: 3/25/57

PHYSICIAN'S NAME (Type): James A. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-27-1957
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 26 1957
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1370 **CERTIFICATE OF DEATH** Reg. Dist. No. 01407

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 408 Chester Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Brenda Middle Ann Last Makell
4. DATE OF DEATH: Month 2 Day 26 Year 1957
5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-1-56
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 4 Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Albert Makell Jr.
14. MOTHER'S MAIDEN NAME: Betty E. Grant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Albert Makell Jr. Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 days
DUE TO
(b) cerebral anoxia — 7 days
DUE TO
(c) heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

493X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): heart failure

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 17, 1957, to Feb 25, 1957, that I last saw the deceased alive on Feb 25, 1957, and that death occurred at midnight, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil H. Sims M.D. ADDRESS (Street, city or town, state): Annapolis, Maryland DATE SIGNED:
PHYSICIAN'S NAME (Type): NEIL H. SIMS.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-1-57
22c. NAME OF CEMETERY OR CREMATORY: Annapolis Natl.
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese Jr. ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 2-28-57
24b. REGISTRAR'S SIGNATURE: Thos. J. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1371 **CERTIFICATE OF DEATH** 01408

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Crownsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First FERRIS — Middle — Last MC KNEW
4. DATE OF DEATH: Month FEBRUARY — Day 15 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 3, 1940
9. AGE (In years last birthday): 17 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: High School (3rd year)
11. BIRTHPLACE (State or foreign country): Gotts, Station, Md.
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Roland W. McKnew
14. MOTHER'S MAIDEN NAME: Ruth V. Downs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-36-3510
17. INFORMANT: Roland W. McKnew- Father- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal septicemia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
0: 3.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/14, 1957, to 2/15, 1957, that I last saw the deceased alive on 2/15, 1957, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedeman M.D. — ADDRESS (Street, city or town, state): 90 Catherdral Street, Annapolis, Md. — DATE SIGNED: 2/17/57

PHYSICIAN'S NAME (Type): John Hedeman MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-19-57
22c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial Cemetery
22d. LOCATION (City, town, or county) (State): Millersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: ANNNAPOLIS, MD.
24a. REC'D BY REGISTRAR: DATE FEB 19 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1372 **CERTIFICATE OF DEATH** 01409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b: ~~4 yrs.~~
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Maryland
d. STREET ADDRESS: 107 Severn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Baby Boy Middle: Last: McKOWN
4. DATE OF DEATH Month: February Day: 21 Year: 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-21-57
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: 6 Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Elliott McKOWN
14. MOTHER'S MAIDEN NAME: Alice Lenore LUCAS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: - -
17. INFORMANT: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity with Immaturity

776 x

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 FEB, 19 57, to 21 FEB, 1957, that I last saw the deceased alive on 21 FEB, 19, and that death occurred at 3:05P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard D. Sheehan M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 21 FEB 1957

PHYSICIAN'S NAME (Type): RICHARD D. SHEEHAN LT MC USNR U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-25-1957
22c. NAME OF CEMETERY OR CREMATORY: U.S. Naval Academy
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 25 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Page [illegible] and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01410

1413 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1yr.3mos.16days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3Y 07-4.
d. STREET ADDRESS: 507 Laurens St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Viola Middle Last Meads
4. DATE OF DEATH: Month 2 Day 4 Year 1957
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Not given
9. AGE (In years last birthday): 81? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not given
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Not given
14. MOTHER'S MAIDEN NAME: Not given
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records Address: Crownsville State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced metastatic cancer of the breast

170X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pneumonia, General wasting

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/27, 1956 to 2/4, 1957, that I last saw the deceased alive on 2/31, 1957 and that death occurred at 10 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE Lionel McHenry Mapp. M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/5/57

PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~
22b. DATE THEREOF 2/9/57
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn
22d. LOCATION (City, town, or county) Baltimore (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Price ADDRESS 661 W. Baltimore St.
24a. REC'D BY REGISTRAR DATE 2-13-57
24b. REGISTRAR'S SIGNATURE E. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01411

1414 **CERTIFICATE OF DEATH**

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park.
c. LENGTH OF STAY IN 1b 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dividing Rd - Manhattan Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park MD.
d. STREET ADDRESS Dividing Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: John Middle: Brooks Last: Mellor.
4. DATE OF DEATH Month: 2 Day: 16 Year: 1957.

5. SEX M.
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAY 4, 1880
9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Sykesville
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Edwin M. Mellor
14. MOTHER'S MAIDEN NAME Mary W. Lemmon.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Rose Bachman. Daughter. Address (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial INFarction. — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b) Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Emphysema-Bronchiectasis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19____, to 15 Feb, 19 57, that I last saw the deceased alive on 2-15-57, 19____, and that death occurred at 2:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R. Hahn M.D. ADDRESS (Street, city or town, state) Severna Park Md DATE SIGNED 2-16-57

PHYSICIAN'S NAME (Type) Robert R. HAHN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/18/57
22c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery
22d. LOCATION (City, town, or county) (State) Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tickner & Son ADDRESS Novak & Fa Aves.
24a. REC'D BY REGISTRAR DATE Feb. 18, 1957
24b. REGISTRAR'S SIGNATURE L. J. Dealley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01412

1373 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY: A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HOMEWOOD NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
d. STREET ADDRESS: BODKIN CREEK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: PAUL Middle: MILLER Last:
4. DATE OF DEATH: Month: FEB. Day: 3 Year: 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB. 18, 1867
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATER MAN
10b. KIND OF BUSINESS OR INDUSTRY: CRABBING
11. BIRTHPLACE (State or foreign country): BAVARIA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: IRVIN T. JOHNSON Address: RIVIERA BEACH KENWOOD RD MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MALNUTRITION — INTERVAL BETWEEN ONSET AND DEATH: 3 WKS.
DUE TO
(b) METASTATIC BASALCELL CARCINOMA — 1 YEAR
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 199.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to 3 FEB, 1957, that I last saw the deceased alive on 3 FEB, 1957, and that death occurred at 10:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D. ADDRESS (Street, city or town, state): 4 Woodgate Ave DATE SIGNED: 5 Feb 1957
PHYSICIAN'S NAME (Type): EDWARD S. BECK Annapolis Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB. 6, 1957
22c. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEM
22d. LOCATION (City, town, or county) (State): RITCHIE HWY A.A. CO., MD

23. FUNERAL DIRECTOR'S SIGNATURE: George J. Gorce ADDRESS: 4001 RITCHIE HWY
24a. REC'D BY REGISTRAR DATE: 2-6-57
24b. REGISTRAR'S SIGNATURE: Wm. J. Zuschlag

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1415 **CERTIFICATE OF DEATH** 01413

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Not given
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Walter — Middle — Last Mosley
4. DATE OF DEATH: Month 2 — Day 27 — Year 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Gravel Pit
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Clem Mosley
14. MOTHER'S MAIDEN NAME: Amy Richardson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Mrs. Jessie Davis, daughter — Address: 205 E. 11th St., Wilmington, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

450.0

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cancer of prostate gland

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/26, 1957, to 2/27, 1957, that I last saw the deceased alive on 2/26, 1957, and that death occurred at 4:15 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 2/27/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-2-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Dean Y — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR — DATE: 2-28-57
24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01414

Items 3-4-9: G211 - 3/5/57 1374

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndal, Glen Burnie, Maryland
d. STREET ADDRESS: 4 Ferndale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise — Middle: Law — Last: Nass

4. DATE OF DEATH: Month: February — Day: 22 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-10-~~86~~ 85
9. AGE (In years last birthday): 71 ~~70~~ yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: — — —
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Gottlob Heinrich Seidle
14. MOTHER'S MAIDEN NAME: Mina Caroline Schifferer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John Nass — Address: 4 Ferndale Road, Ferndale, Glen Burnie, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Abcess with Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
170X
DUE TO
(b) Metastatic Carcinoma of Brain, Lung, and Liver — 1 year
DUE TO
(c) Carcinoma of Breast (Right) — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 17 February, 19 57, to 22 February, 19 57, that I last saw the deceased alive on 22 February, 1957, and that death occurred at 3:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Vincent P. Butler, Jr. M.D. — ADDRESS (Street, city or town, state): U. S. Naval Hospital — DATE SIGNED: 2/22/57

PHYSICIAN'S NAME (Type): Vincent P. Butler, Jr. — Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 25-57
22c. NAME OF CEMETERY OR CREMATORY: Silverbrook Cemetery
22d. LOCATION (City, town, or county) (State): Wilmington, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: F. T. Singleton — ADDRESS: Glen Burnie
24c. REC'D BY REGISTRAR: DATE FEB 27 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01415

1416. **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1 PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: A. A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Sarah Middle: Jane Last: Neal

4. DATE OF DEATH: Month: 2 Day: 27 Year: 1957

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-15-1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: Days:

IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Boston

14. MOTHER'S MAIDEN NAME: Josie Watkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Layman Address: Edgewater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage

DUE TO (b):

DUE TO (c):

331 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-26-56, 19____, to 2-27-57, 19____, that I last saw the deceased alive on 2-22-57, 19____, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. T. Ally M.D. ADDRESS (Street, city or town, state): G. L. Gaithers DATE SIGNED: 3-25-57

PHYSICIAN'S NAME (Type): A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremated

22b. DATE THEREOF: 3-2-57

22c. NAME OF CEMETERY OR CREMATORY: Chews Chapel

22d. LOCATION (City, town, or county) (State): Owensville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Case ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: OCT 4 1957

24b. REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1417

01416

Reg. Dist. No. 14

1 PLACE OF DEATH
a. COUNTY: A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sunset Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD.
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sunset Beach
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First PATRICIA Middle ANN Last NOLAN

4. DATE OF DEATH: Month 2 Day 1 Year 19 57

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/30/55 56
9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months ; Days
IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland Balto.City
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas
14. MOTHER'S MAIDEN NAME: Margaret Squires

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family - Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
491X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 31, 1957, to Feb 1, 1957, that I last saw the deceased alive on January 31, 1957, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): RED 8 Box 442 Pasadena DATE SIGNED: Feb. 1, 1957

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 2/4/57
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: McCully Funeral Homes - 130 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE: FEB 1 1957
24b. REGISTRAR'S SIGNATURE: L. J. DeMay

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

204,321 XV.5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1375 **CERTIFICATE OF DEATH** Reg. Dist. No. 01417

1. PLACE OF DEATH a. COUNTY: A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arth. Station
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Della Middle Mae Last North
4. DATE OF DEATH: Month 2 Day 1 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-24-1882
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Benwood West Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Jacob Strober
14. MOTHER'S MAIDEN NAME: Emma Marshall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles H. North Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) urenia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardio-vascular renal disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): cirrhosis of liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1943, 19____, to Feb. 1, 19 57, that I last saw the deceased alive on Feb. 1, 19 57, and that death occurred at 1:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Borssuck M.D. ADDRESS (Street, city or town, state): Amos Garrett Blvd., Annapolis, Md. DATE SIGNED: 2/3/57

PHYSICIAN'S NAME (Type): S. Borssuck, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-4-57
22c. NAME OF CEMETERY OR CREMATORY: London Park
22d. LOCATION (City, town, or county) (State): Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE 2/5/57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1376 **CERTIFICATE OF DEATH** 01418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 619 Severn Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 619 Severn Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adalbert Middle: J. Last: Oktavec
4. DATE OF DEATH: Month: 2 Day: 28 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-14-1880
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool MAKER
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt Ret.
11. BIRTHPLACE (State or foreign country): CZECHOSLOVAKIA
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: JOHN OKTAVEC
14. MOTHER'S MAIDEN NAME: MARY BLAKA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: AGNES M. OKTAVEC Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure - Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

DUE TO (b) Arteriosclerotic Heart Disease — unknown

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 JAN, 1957, to 28 FEB, 1957, that I last saw the deceased alive on 28 FEB, 1957, and that death occurred at 8:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D. ADDRESS (Street, city or town, state): 41 Southgate Ave DATE SIGNED: 3/1/57

PHYSICIAN'S NAME (Type): EDWARD S. BECK MD ANNAPOLIS, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-2-57
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: MAR 2 1957
24b. REGISTRAR'S SIGNATURE: U. Unwin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1377 **CERTIFICATE OF DEATH** 01419

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Galloway Middle: Last: Parker
4. DATE OF DEATH: Month: 2 Day: 20 Year: 1957
5. SEX: Male
6. COLOR OR RACE: Cd
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-1-1893
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Nelson Parker
14. MOTHER'S MAIDEN NAME: Bobbie Parker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-30-3093
17. INFORMANT: Lucy Parker — Davidsonville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: Time

DUE TO (b) Severe hypertension — 7 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/18, 1957 to 2/20, 1957 that I last saw the deceased alive on 2/20, 1957, and that death occurred at 8:15 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedeman M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 2/23/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-25-57
22c. NAME OF CEMETERY OR CREMATORY: Adams Chapel
22d. LOCATION (City, town, or county) (State): Bayard, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Pease Jr. ADDRESS: Annapolis, Md.
24a. FILED BY REGISTRAR DATE: FEB 26 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. Tuesday

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1378 **CERTIFICATE OF DEATH** 01420

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 15 Leff St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 15 Leff St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Daniel Middle Lost Peters
4. DATE OF DEATH: Month 2 Day 9 Year 1957
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-9-1892
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months 12 Days; IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George A. Peters
14. MOTHER'S MAIDEN NAME: Lilla Ford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-28-0755
17. INFORMANT: Georgianna Peters Address: Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Hypertensive Cardiovascular Dis — 4 years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 30, 1953, to Feb 9, 1957, that I last saw the deceased alive on Feb 8, 1957, and that death occurred at 3 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Faye W Allen M.D. ADDRESS (Street, city or town, state): 62 Cathedral DATE SIGNED: 2-11-57
PHYSICIAN'S NAME (Type): FAYE W ALLEN Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-13-57
22c. NAME OF CEMETERY OR CREMATORY: Fowlers Chapel
22d. LOCATION (City, town or county) (State): Best Gate Md.
23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 2/15/57
24b. REGISTRAR'S SIGNATURE: Dr. Wm. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1418 **CERTIFICATE OF DEATH** 01421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHALK PT. West River, Md.
c. LENGTH OF STAY IN 1b: 60 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MD b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHALK PT. West River, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILSON Middle Last PHIPPS
4. DATE OF DEATH: Month Feb. Day 2 Year 1957
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 2 1871
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OYSTER + FARM
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DEALE, MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: T. NICHALAS Phipps
14. MOTHER'S MAIDEN NAME: Louinia KIRCHNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Louis N. Phipps Address: 67 College Ave, Annapolis MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, left upper lobe — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) congestive failure — 3 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4941

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): General arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1955, to 2 January, 1957, that I last saw the deceased alive on 2 January, 1957, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F D Hendricks M.D. ADDRESS (Street, city or town, state): Shady Side, Maryland DATE SIGNED: 4 Feb 57

PHYSICIAN'S NAME (Type): F D Hendricks Shady Side Maryland 4 Feb 57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/4/57
22c. NAME OF CEMETERY OR CREMATORY: St. James
22d. LOCATION (City, town, or county) (State): TRACYS AA Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: BERNARD Hardesty ADDRESS: Edgewater Md.
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE: U. Parnell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01422

1419

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mos.18days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 2605 Spellman Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: — Last: Powell
4. DATE OF DEATH: Month: 2 — Day: 28 — Year: 1957
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/12/03 ?
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY: U. S.
13. FATHER'S NAME: Not given
14. MOTHER'S MAIDEN NAME: Mahalia Pinkett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unk. — (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records — Address: State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia

442X

DUE TO (b) Hypertensive cardiovascular renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/27, 19 57, to 2/28, 19 57, that I last saw the deceased alive on 2/28, 1957, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 2/28/57
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 3/4/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
22d. LOCATION (City, town, or county) (State): Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Geo. M. Kelson — ADDRESS: 1348 N. Calhoun St.
24a. REC'D BY REGISTRAR DATE: 3/5/57
24b. REGISTRAR'S SIGNATURE: F. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1420 **CERTIFICATE OF DEATH**

01423 M

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRCHARD BEACH
c. LENGTH OF STAY IN 1b: 7 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7800 HIGH POINT ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 C. RCHARD BEACH
d. STREET ADDRESS: 7800 HIGH POINT RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICE Middle J. Last POWERS
4. DATE OF DEATH: Month FEB. Day 25 Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT. 31, 1874
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: SAMUEL TAYLOR
14. MOTHER'S MAIDEN NAME: ROSE GARVEY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOSEPH S. TAYLOR Address: 7800 HIGH PT. RD. AA.C. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b) Arteriosclerotic cardiovascular disease — 7 years
DUE TO (c)
422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebro-vascular accident - 1950
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 10, 1950, to Feb. 25, 1957, that I last saw the deceased alive on Feb. 24, 1957, and that death occurred at 2:11 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): Pasadena, Maryland DATE SIGNED: Feb. 25, 1957

PHYSICIAN'S NAME (Type): R.M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB 27, 1957
22c. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL CEM
22d. LOCATION (City, town, or county) (State): BALTIMORE MD

23. FUNERAL DIRECTOR'S SIGNATURE: George J. Gonce ADDRESS: 4001 RITCHIE HWY
24a. REC'D BY REGISTRAR DATE: MAR 1 1957
24b. REGISTRAR'S SIGNATURE: L. J. Dellaby

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1421 **CERTIFICATE OF DEATH** Reg. Dist. No. 1424

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6yrs.5mos.10days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 1324 Orleans St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Miranda Middle: Lost: Price
4. DATE OF DEATH: Month: 2 Day: 10 Year: 19 57
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/1/79
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Kane Jacobs
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records Address: State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia

44 2X

DUE TO (b) Arteriosclerotic cardiovascular-renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dehydration, Malnutrition, Decubitus ulcers

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/10, 19 57, to 2/10, 19 57, that I last saw the deceased alive on 2/8, 19 57, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state): Crownsville, Md. DATE SIGNED: 2/10/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): 2-14-57
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Mt Cal.
22d. LOCATION (City, town, or county) (State): Brooklyn Md. Anne

23. FUNERAL DIRECTOR'S SIGNATURE: E. O. Nelson ADDRESS: 1000 Beverly Ave
24a. REC'D BY REGISTRAR DATE: FEB 13 1957
24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1379 Reg. Dist. No. 01425

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carvel Hall

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis,
d. STREET ADDRESS: Carvel Hall
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: F. Middle: Elizabeth Last: Pumphrey
4. DATE OF DEATH: Month 2 Day 2 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-25-1882
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg nurse
10b. KIND OF BUSINESS OR INDUSTRY: Reg nurse
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Winter Pumphrey
14. MOTHER'S MAIDEN NAME: Fannie Friesiesen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Henry E. Smith Address: Blandair Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: Sudden
331X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D.
EXAMINER'S NAME (Type): E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2/2/57

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE 2/5/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01426

CERTIFICATE OF DEATH

1422

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Glen Burnie
LENGTH OF STAY (In this place) 77 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marley Station Rd Glen Burnie P.O

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Glen Burnie
STREET ADDRESS (If rural give location) Marley Station Rd, Glen Burnie, P.O.

3. NAME OF DECEASED (Type or Print) (First) Louis (Middle) Edgar (Last) Pumphrey

4. DATE OF DEATH (Month) Feb (Day) 10 (Year) 1957

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH August 15, 1879
9. AGE last birthday 77 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate
10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Marley Station Rd Glen Burnie P.O
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Osborne Stallings Pumphrey
14. MOTHER'S MAIDEN NAME Leonora Stump Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS Anne Wilson Pumphrey - Same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A)	Respiratory Failure	30 MIN
ANTECEDENT CAUSE(S)	DUE TO (B)	Congestive Heart Failure	1 hr.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C)	Coronary Occlusion	25 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/22, 1956, to 2/10, 1957, that I last saw the deceased alive on 2/8, 1957, and that death occurred at 8 A.M. from the causes and on the date stated above.

SIGNATURE H. W. Richard M.D. ADDRESS (Street, city, town, state) 15 Cathedral Glen Burnie Md DATE SIGNED 2/10/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Feb. 13, 1957
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) Brooklyn Park (State) Md.

24. REC'D BY REGISTRAR DATE Feb 12, 1957
REGISTRAR'S SIGNATURE F. J. D'Oliva
25. FUNERAL DIRECTOR'S SIGNATURE R. F. Singleton
ADDRESS Glen Burnie, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01427

1423

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort G. G. Meade

LENGTH OF STAY (in this place): DOA

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1929 E. Reece Road

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade

STREET ADDRESS (If rural give location): 1929 E. Reece Road

3. NAME OF DECEASED (Type or Print): WINIFRED (First) ANN (Middle) RAU (Last)

4. DATE OF DEATH (Month) (Day) (Year): 6 February 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 28 July 1921

9. AGE last birthday: 35 Yr yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Francis Murray

14. MOTHER'S MAIDEN NAME: Alice Cecilia Nevins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Husband, 1929 E. Reece Road, Fort George G. Meade, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Occlusion — Immediate

ANTECEDENT CAUSE(S) DUE TO (B) Coronary Occlusion — Immediate

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Feb 6 Feb 1957, to ——, 19..., that I last saw the deceased alive on D.O.A. DOA, 19..., and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE: S. H. Tarabishy — SAID H. TARABISHY, Maj, MC, M.D. — ADDRESS (Street, city, town, state): U. S. Army Hospital Fort Meade Md. — DATE SIGNED: 6 Feb 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — DATE THEREOF: 2-11-57 — NAME OF CEMETERY OR CREMATORY: Arlington — LOCATION (City, town, or county) (State): Wash D.C.

24. REC'D BY REGISTRAR — DATE 7 Feb 57 — REGISTRAR'S SIGNATURE: W.L.Saylor — W.L.SAYLOR, 1ST LT, MSC.

25. FUNERAL DIRECTOR'S SIGNATURE: Thomas S. Dorsey — ADDRESS: WM COCK, INC, Baltimore, Maryland

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1424

CERTIFICATE OF DEATH

01428

Reg. Dist. No. 028

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 22 yrs. 1 mo. 15 da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 900 Lake St., Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Dorothy; Middle: ; Last: Robbins
4. DATE OF DEATH: Month: 2; Day: 8; Year: 1957
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/12/08
9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Jack Dennis
14. MOTHER'S MAIDEN NAME: Bessie Toadvine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records — Address: Crownsville State Hosp. Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Damage — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO
(b) Generalized Arteriosclerosis
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 1/25, 1948, to 2/8, 1957, that I last saw the deceased alive on 2/7, 1957, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ludwig Benedict, M. D. M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 2/8/57
PRINTED NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 2/11/57
22c. NAME OF CEMETERY OR CREMATORY: Green Acres
22d. LOCATION (City, town, or county) (State): Salisbury Md.
22. FUNERAL DIRECTOR'S SIGNATURE: J. F. Stewart
ADDRESS: Funeral Home Salisbury Md.
24a. REC'D BY REGISTRAR: DATE 2/6/57
24b. REGISTRAR'S SIGNATURE: Katherine Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1380 **CERTIFICATE OF DEATH** 01429

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Anrapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 45 Madison Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ANDREW Middle L Last ROBINSON
4. DATE OF DEATH: Month FEBRUARY Day 3 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1880
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Pipe fitter
10b. KIND OF BUSINESS OR INDUSTRY: US Gov.
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Robinson
14. MOTHER'S MAIDEN NAME: Rebecca Puckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mrs Magdalene Robinson- Wife- Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Lung Metastatic — 1½ YRS
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAR., 1955, to 3 FEB., 1957, that I last saw the deceased alive on 3 FEB., 1957, and that death occurred at 12 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M.D. — ADDRESS (Street, city or town, state): Southgate Ave, Annapolis, Md. — DATE SIGNED:

NAME (Type): Edward S. Beck

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5-57
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: HOF. INC. FUNERAL HOME Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 2/5/57
24b. REGISTRAR'S SIGNATURE: Wm. J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1425 CERTIFICATE OF DEATH

Reg. Dist. No. 01430

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Skinners Row

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gibson Island
d. STREET ADDRESS: Skinners Row
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Russel — Middle: Joseph — Last: Davitz
4. DATE OF DEATH: Month: Feb. — Day: 6 — Year: 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 30, 1894
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Supr.
10b. KIND OF BUSINESS OR INDUSTRY: Dolphinut Mill
11. BIRTHPLACE (State or foreign country): Penn.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jerome J. Davitz
14. MOTHER'S MAIDEN NAME: Stella F. --
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. M.C. Davitz — Address: Gibson Island

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized carcinomatosis
DUE TO (b) Carcinoma of prostate
DUE TO (c)

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956 to February 6, 1957 that I last saw the deceased alive on January 30, 1957, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Karl F. Mech, M.D. M.D. — ADDRESS (Street, city or town, state): 11 E. Chase St., Balto-2, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): KARL F. MECH, M.D. — 11 E. CHASE ST., BALTO-2, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2-8-57
22c. NAME OF CEMETERY OR CREMATORY: Lowson Park Crematory
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]
24a. REC'D BY REGISTRAR: DATE: [illegible]
24b. REGISTRAR'S SIGNATURE: L. J. Dellbas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01431

1426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie

c. LENGTH OF STAY IN 1b: 16 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 1215 Dorsey Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Same — b. COUNTY: Same

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same

d. STREET ADDRESS: Same

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Anna Middle: Marie Last: Shenton

4. DATE OF DEATH Month: February Day: 1st. Year: 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 7/11/17

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Wilkinson

14. MOTHER'S MAIDEN NAME: Anna Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-18-8443

17. INFORMANT Address: Norman Shenton (husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging herself to the railing

DUE TO (b) on the back porch of her home with a belt. — Sudden

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging herself to the railing of porch with a belt.

20c. TIME OF INJURY Hour ? a. m. p. m. Month, Day, Year 2/3/57 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back porch of home.

20f. (City or town) Glen Burnie (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED February 4th. 1957

EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/6/57

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d. LOCATION (City, town, or county) Baltimore, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Tony [illegible]

ADDRESS Hopping and Kirkley Funeral Home, Glen Burnie,

24a. REC'D BY REGISTRAR DATE FEB 8 1957

24b. REGISTRAR'S SIGNATURE L. J. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 filed 2-26-57 et

1427

01432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5 mos.1day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 2216 Druid Hill Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rachel — Middle: Davenport — Last: Smith

4. DATE OF DEATH: Month: 2 — Day: 12 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/25/~~97~~ 1896

9. AGE (In years last birthday): 60~~99~~ yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: ISaac Davenport

14. MOTHER'S MAIDEN NAME: Linda Davenport

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Hospital Records — Address: State Hospital Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

443X

DUE TO (b): Hypertensive Arteriosclerotic Cardiovascular Disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pyelitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/2, 19 57, to 2/12, 19 57, that I last saw the deceased alive on 2/11, 19 57, and that death occurred at 4:30p.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 2/13/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 16, 1957

22c. NAME OF CEMETERY OR CREMATORY: Shiloh Cemetery

22d. LOCATION (City, town, or county) (State): Northumberland Co., Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph L Russ — ADDRESS: 2222 N. North ave

24a. REC'D BY REGISTRAR: DATE 13 1957

24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01433

1381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: Maryland b. COUNTY: A. A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt. 4 Box 64

d. STREET ADDRESS: Rt. 4 Box 64

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: John Middle: R. Last: Thomas Jr.

4. DATE OF DEATH Month: 2 Day: 14 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-25-1872

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John R. Thomas

14. MOTHER'S MAIDEN NAME: Rachel Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: —

17. INFORMANT: Oliver Thomas Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-3-57, 19____, to 2-14-57, 19____, that I last saw the deceased alive on 2-13-57, 19____, and that death occurred at 3:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. T. Allen M.D. ADDRESS (Street, city or town, state): 62 Cathedral St DATE SIGNED: 2-16-57

PHYSICIAN'S NAME (Type): G. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: 2-17-57

22c. NAME OF CEMETERY OR CREMATORY: Broad Neck

22d. LOCATION (City, town, or county) (State): Skidmore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 2-16-1957

24b. REGISTRAR'S SIGNATURE: Wm. J. Fraeche

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01434

1382

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2. Arnold
d. STREET ADDRESS: 139 CliftonAve
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle LOU Last THOMAS
4. DATE OF DEATH: Month Feb. Day 17, Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 8, 1957
9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days 9 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~Mr~~ George Thomas
14. MOTHER'S MAIDEN NAME: Patercia R. Kenline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr George Thomas -Father- Address: same and # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/14, 1957, to 2/17, 1957, that I last saw the deceased alive on Feb. 16, 1957, and that death occurred at 2 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil H. Sims M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type): Neil Sims MD — 95 Catherdral St. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-18-57
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ben C. Hopping Jr.
ADDRESS: HOPPING FUNERAL HOME Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 20 1957
24b. REGISTRAR'S SIGNATURE: Jm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01435

1428

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE, LENGTH OF STAY (in this place) 13 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD. COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDENTON

STREET ADDRESS (If rural give location) 7 W. TELEGRAPH ROAD

3. NAME OF DECEASED (Type or Print) (First) ROY (Middle) LEE (Last) THOMAS, II

4. DATE OF DEATH (Month) FEB (Day) 19, (Year) 19 57

5. SEX MALE

6. COLOR OR RACE CAUCASION

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —

8. DATE OF BIRTH FEB 6, 1957

9. AGE last birthday — yrs.

IF UNDER 1 YEAR: Months — Days 13

IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ROY LEE THOMAS

14. MOTHER'S MAIDEN NAME KAYE MARSDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS FATHER, ROY LEE THOMAS, 7 W. TELEGRAPH ROAD, EDENTON, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 6 Feb. 1957

ANTECEDENT CAUSE(S) DUE TO (B) Anoxia — Estimated 5 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Probable intracranial hemorrhage — Estimated 13 days.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 6 Feb., 19 57, to 19 Feb., 19 57, that I last saw the deceased alive on 19 Feb., 19 57, and that death occurred at 5:35 P.M., from the causes and on the date stated above.

SIGNATURE Richard M. McGrane M.D. ADDRESS (Street, city, town, state) DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL.

DATE THEREOF 2 Feb. 57

NAME OF CEMETERY OR CREMATORY BALTO NATIONAL

LOCATION (City, town, or county) BALTO MD. (State)

24. REC'D BY REGISTRAR DATE FEB 19, 57

REGISTRAR'S SIGNATURE W. H. Taylor MSC W. H. TAYLOR, BTLT.

25. FUNERAL DIRECTOR'S SIGNATURE William Cook Jr. William Cook, 1217 St. Paul St. Baltimore

ADDRESS Maryland

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1383 **CERTIFICATE OF DEATH** 01436

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A. A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XI. Gambrills
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First Wesley Middle S. Last Turner
4. DATE OF DEATH Month 2 Day 21 Year 1957
5. SEX Male
6. COLOR OR RACE Col
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-3-1882
9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY U. S. Naval Acad
11. BIRTHPLACE (State or foreign country) Lutland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Lim Turner
14. MOTHER'S MAIDEN NAME Eliza Hamilton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Ida Turner Address Gambrills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-4-57 19____, to 2-21-57 19____, that I last saw the deceased alive on 2-20-57 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE A. T. Allen M.D. ADDRESS (Street, city or town, state) 61 Cathedral St DATE SIGNED 2-23-57

PHYSICIAN'S NAME (Type) A. T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-24-57
22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor
22d. LOCATION (City, town, or county) (State) Chesterfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Fusco ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE FEB 26 1957
24b. REGISTRAR'S SIGNATURE Wm. J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01437

1429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 205 S. Hammonds Ferry Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Linthicum
d. STREET ADDRESS: 205 S. Hammonds Ferry Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mae — Middle: Commie — Last: Ward

4. DATE OF DEATH: Month: February — Day: 7 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept.25/97
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cleaning (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Beshan Vet. Hosp.
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sam Woods
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): — —
16. SOCIAL SECURITY NO.: 191 20 4944
17. INFORMANT: Mrs. Mary Jane Ward — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
445X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Nephro-Sclerosis — 4 yrs.
DUE TO
(c) Malignant Hypertension — 15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 24, 1952, to Feb. 7, 1957, that I last saw the deceased alive on Feb. 3, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Milton Linthicum — M.D. — ADDRESS (Street, city or town, state): 106 W. Maple Road — DATE SIGNED: 2/8/57

PHYSICIAN'S NAME (Type): C. Milton Linthicum — Linthicum Heights, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb.11/57
22c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Richard L. Smyth
ADDRESS: Glen Burnie, Maryland
24a. RECD BY REGISTRAR DATE: FEB 13 57
24b. REGISTRAR'S SIGNATURE: W. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1430 **CERTIFICATE OF DEATH**

Reg. Dist. No. 01438

1. PLACE OF DEATH a. COUNTY: A.A.CO., Md. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harmons
c. LENGTH OF STAY IN 1b: 50Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harmons, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A.A.Co., Md.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Harmons
d. STREET ADDRESS: Harmons, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest Middle: Lost: Watts
4. DATE OF DEATH: Month: 2/2/57 Day: Year: 19
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/10/ 1865
9. AGE (In years last birthday): 91 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Charles County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Harrison Watts, Address: Harmons, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insuff. — INTERVAL BETWEEN ONSET AND DEATH: 1/27/56 to 2/2/57

475X

DUE TO (b) Upper Respiratory Infection

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 3 1957 to Feb. 2 1957, that I last saw the deceased alive on Feb. 2 1957, and that death occurred at 11:50 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank E. Shipley M.D. ADDRESS (Street, city or town, state): Savage, Md. DATE SIGNED: 2/3/57

PHYSICIAN'S NAME (Type): Frank E. Shipley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/6/57
22c. NAME OF CEMETERY OR CREMATORY: Sb. Rest Cemetery
22d. LOCATION (City, town, or county) (State): Harmons, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Law, ADDRESS: 802 Madison Avenue.
24a. REC'D BY REGISTRAR DATE: FEB 6 1957
24b. REGISTRAR'S SIGNATURE: Clara Dashiell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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